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CITIZENS RESEARCH COUNCIL OF MICHIGAN

The Lack of Data Impedes Cost-Effective Health Care in Michigan's Prisons

This Memorandum summarizes Report #416

3 Key Takeaways

- Providing health care to prisoners is a costly endeavor, yet the state does not adequately assess whether it meets its legal obligations to prisoners in the most cost-effective way.
- Improving quality of care and maximizing cost-effectiveness of the prison health care system requires a significant amount of data to identify and understand potential cost-drivers.
- Since every resident in Michigan has a stake in the quality and efficiency of the prison health care system, the state should ensure that the relevant data regarding prisoner health and spending be made available to policymakers and the general public.

The prison system, like roads and schools, is a part of the government's core architecture that aims to benefit society. While every citizen has a stake in the quality and efficiency of this system, the needs of prisoners are often overlooked and rarely prioritized by state policymakers and the public. Prisoners are too often seen as a collection of undesirable individuals that burden the state, as opposed to a necessary component of the state's responsibility to its people.

The state has an obligation to operate prisons in a manner that meets the basic needs of prisoners. Health care is a primary component of those operations and accounts for a large portion of the corrections budget. To that end, the state also has a duty to maximize health care quality and efficiency for the benefit of prisoners and the public.

In recent years, the state has spent approximately $300 million per year – roughly three percent of all General Fund dollars – to provide care for more than 30,000 prisoners. These costs are increasing on a per prisoner basis, particularly over the last several years. Minimizing costs without sacrificing quality of care is a monumental goal that requires a great deal of analysis. There are many potential theories as to what primarily drives prison health care costs and, accordingly, many different policy solutions. In order to assess how to allocate funding, it is necessary to analyze the true cost of prison health care and break down the primary drivers of those costs.

Achieving this goal requires extensive data about prisoner health care that is largely unavailable to the public. Much of the raw data is tracked by the Michigan Department of Corrections (MDOC). However, MDOC is only required to share high-level data with the public and is not required to provide sufficiently detailed reports to the legislature about its fulfillment of its obligations. Identifying cost-drivers within the prison health care system and recommending policy solutions depends on the availability of this data. The first legislative step for improving prison health care services and efficiently managing the associated

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costs, therefore, is taking action to require the collection and public reporting of aggregated prisoner health care information for analysis.[A]

Legal Obligations

The obligation to provide health care to prisoners flows from legal standards set by the U.S. and state constitutions, as well as federal and state laws, regulations, and policy. In addition to the obligation to prisoners to provide health care, governments – to protect themselves against litigation and waste – have concurrent obligations to the public to carry out their legal and ethical obligations in an effective manner while being good stewards of public resources.

U.S. citizens have a constitutional protection against cruel and unusual punishment under the Eighth Amendment. A state's failure to provide adequate health care, including deliberate indifference to the medical needs of prisoners, violates the constitution. Michigan also has its own analogous constitutional provision related to punishments.

In addition to the constitutional baseline, states may also establish additional requirements and parameters around prison health care through statutes, rules, and policies. In Michigan, a variety of laws and policies regulate the structure and delivery system of prisoner health care and create additional legal obligations on the state. Failing to meet the standard of care set out in the Eighth Amendment, the Michigan Constitution, or self-imposed statutory and regulatory obligations not only opens the state up to legal challenges from prisoners and/or their families, but also threatens societal trust in the order and integrity of the legal system.

[A] Citizens Research Council's goal at the beginning of this project was to conduct the analysis proposed by this paper – studying whether the state is meeting its obligations related to prisoner health care and how efficiently it is doing so. The Research Council's requested summary statistics and aggregated health data from MDOC to carry out this analysis, but the department did not produce any data.

States must fulfill this prisoner health care obligation to serve and protect the public, and the public has a stake in whether this legal standard is met and how the state goes about meeting it. First, meeting these obligations helps to protect the state's financial interests from litigation brought by prisoners and/or their families, and the effects of this financial loss trickle down to individual taxpayers. In addition, meeting the health care needs of prisoners serves the state's interest in rehabilitation which directly impacts recidivism and public safety.

Prison Health Care Delivery in Michigan

In Michigan, the Department of Corrections (MDOC) is responsible for the general health, psychiatric health, and medication needs of prisoners in its jurisdiction, which includes state correctional facilities, reentry centers, and some county jails. The department delivers these services in conjunction with a contracted vendor who provides physicians and mid-level providers for prisoner general health, psychiatric, and addiction treatment needs. Standards for care are determined by MDOC policies, terms agreed to by the department and its contractor, and evidence-based medical guidelines.

The department shares the financial risk with the contractor by blending two different financial models: cost-plus and capitation. The cost for services starts from a base capitated rate for the care provided by the physicians and providers employed by the contractor, and any cost differential between the base rate and actual rate is shared between the state and the contractor. The cost sharing structure is intended to incentivize the contractor to manage prisoner healthcare on-site and minimize the use of off-site services. Michigan also requires prisoner co-payments which are intended to reduce costs associated with unnecessary medical visits by deterring prisoners from over utilizing health care services.

Spending on Prison Health Care

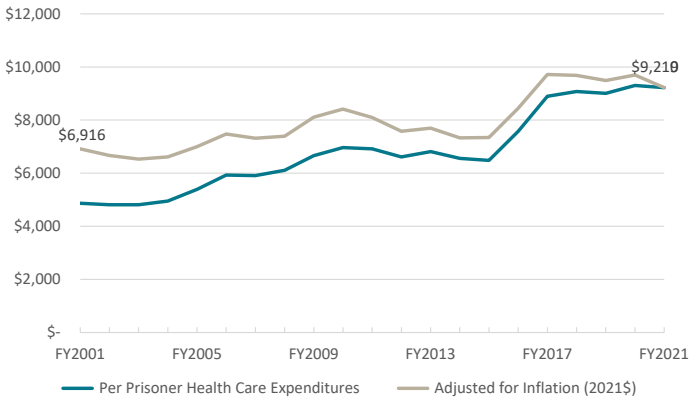
Prison health care is primarily funded by the states, with few avenues for federal support. Collectively, states spent about $8 billion on health care in state prisons in FY2015, accounting for close to 20 percent of states' total corrections budgets for that year. While national data on prison health care spending has not been compiled in the last several years, total corrections spending was more than $70 billion in FY2021.

Michigan spends about $2 billion every year on MDOC operations, almost all of which is general fund money, and that figure has remained relatively consistent over the last two decades. Prison health care spending in particular accounts for nearly $300 million per year and has declined slightly as of FY2021 largely due to the declining prison population. The average per prisoner cost of health care has increased dramatically - 34 percent - over the last two decades, even after adjusting for inflation.

The significant increase in per prisoner health care spending over the last two decades is an important matter of public policy. The limitations on using federal grants to offset state prisoner health care spending places the burden of this on the state's General Fund. It is important for policymakers to understand what the state is getting in exchange for this spending, why the cost of prisoner health care has risen, and what options the state has, if any, to meet its obligations in a way that better serves prisoners and the public alike.

Chart A

Per-Prisoner Health Care Expenditures in Michigan, FY2001 to FY2021



Source: Data compiled from MDOC Statistical Reports and U.S. Bureau of Labor Statistics Detroit CPI. Includes mental health expenditures by Department of Community Health in state prisons prior to FY2011 when that line-item was transferred to the MDOC budget.

Evaluation and Data Needs

Evaluating prison health care requires an analysis of whether health care in prisons is not only adequate, but also whether it is efficient. Allocating resources on potential policy solutions will depend largely on the answers to these questions – if prison health care is found to be neither adequate nor efficient, uncovering the reasons why will guide policymakers towards solutions.

Unfortunately, the state does not currently provide the data necessary to conduct this type of analysis. The MDOC provides limited data on the health of the prison population, health outcomes of incarcerated individuals, and prison health care spending. The available data is insufficient and leaves policymakers and the public in the dark on numerous important questions. The department tracks more data than it releases and uses that data to inform its decisions, but if MDOC does not provide the data to the legislature, stakeholders, and the public, there is no way to know whether the department is fulfilling its obligations.

Public data is needed that measures and tracks the health of individual prisoners and prison populations over time, including demographics, health conditions, and health outcomes. It is important to know what health issues prisoners have when they arrive, what issues they develop while in prison, and how well the department manages those issues. General information from MDOC and broader national survey data paint a consistent picture that the prison population is less healthy than the general population, particularly when it comes to mental health and substance abuse issues. However, more granular data is needed.

Presumably, MDOC has the underlying data necessary to generate the kind of metrics that would be helpful for analysis, as the department does a thorough health intake screening and documents

health visits and treatments throughout a prisoner's time in custody. In particular, the kind of health data that would be valuable for this analysis would include (for both existing prisoners and those entering the system):

- Percentage of prisoners with mental health issues broken down by severity and type/diagnosis
- Percentage of prisoners with substance abuse issues
- Percentage of prisoners with a chronic health condition (not just Hepatitis C) broken down by severity and type/diagnosis
- Percentage of prisoners considered overweight/obese

Potential Cost Drivers

Federal and state stakeholders – including MDOC – have theorized about the causes of increasing prison health care costs, but there remains a limited understanding of exactly which factors actually drive the cost increases. Without a handle on the reasons for the increases, policymakers and the public cannot evaluate whether the state is spending its resources as efficiently as possible, nor can they properly design policies and allocate resources in a manner that might allow the state to rein in the growing expenditures. Similarly, without better data, policymakers do not have a way to forecast whether a particular proposed policy change will move the needle on these expenditures or whether any changes would help prisoners avoid recidivating.

Potential cost drivers include:

- General increases in health care sector costs
- Mental health issues and the rising cost of mental health treatment
- Substance abuse issues
- Infectious disease control
- Preventative care costs
- Specialty/in-patient care utilization increases
- Increased demand for health services
- Prescription drugs costs
- Aging prisoners
- Staff shortages and retention issues

There are a wide variety of reform options available to the department and the legislature. If the data shows that the costs are coming from the health issues of the incoming prison population, policies should focus on social determinants of health to improve economically disadvantaged communities. If the data shows the health of prisoners deteriorates faster than those outside of prison, policies may need to focus on better preventative care. If the data shows that costs are being driven by the aging population, policymakers should look at shortening sentences or promoting early release for those deemed no longer a danger to society. If the problems seem to be associated with poor service delivery, the policy discussion may turn to system reform. Each solution has its own internal logic, but pushing on every available lever is rarely an option. The state has a finite set of resources and there is intense competition over those resources, even among stakeholders that agree ideologically.

The prison population is one of the more understudied societal groups, yet the state and the public maintain a substantial and often unrecognized stake in the well-being of prisoners. The health of prisoners has both economic and broader societal ramifications related to crime, recidivism, and public safety. Crafting policies that aim to improve the health of prisoners while reducing the financial burden on taxpayers could take on many different forms. These proposed policy solutions have been largely based on theoretical causes of poor quality of care and higher costs. Researchers who seek to develop policies for Michigan's prison population need the appropriate data to help tailor their recommendations for improved quality of care and cost-reduction.

The state needs to undertake a serious effort to study prison health care so that it can take targeted steps toward reining in growing costs. That effort starts with gathering, synthesizing, and releasing much more data than the department currently does. MDOC should welcome this effort, but if it does not, the legislature should mandate it.

Endnotes

1 "Prison Health Care: Costs and Quality – How and Why States Strive for High-Performing Systems." Pew Charitable Trusts. October 2017. Appendix C, Table 1. https://www.pewtrusts.org/-/media/assets/2017/10/sfh_prison_health_care_costs_and_quality_final.pdf

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3 "2022 State Expenditure Report, Fiscal Years 2020-2022." National Association of State Budget Offices. Page 61. https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/SER%20Archive/2022_State_Expenditure_Report_-_S.pdf

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5 "Prison Health Care: Costs and Quality – How and Why States Strive for High-Performing Systems." Pew Charitable Trusts. October 2017. https://www.pewtrusts.org/-/media/assets/2017/10/sfh_prison_health_care_costs_and_quality_final.pdf; "Correctional Healthcare and Mental Health." Michigan Department of Corrections. February 20, 2019 testimony to House Appropriations Subcommittee on Corrections. https://www.house.mi.gov/hfa/PDF/Corrections/Corrections_Subcmte_Testimony_MDOC_Healthcare_Presentation_2-20-19.pdf;

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